Form 309A 12/2006   STATE OF UTAH – LABOR COMMISSION
                                       Division of Adjudication
                                 160 East 300 South – 3rd Floor
                                          P. O. Box 146615
                                  Salt Lake City, Utah 84114-6615
                             Phone: (801) 530-6800 Fax: (801) 530-6333
                            MEDICAL TREATMENT PROVIDER LIST

Claimant Name _____   Social Security Number _____
Address _____   Date of Injury _____
            _____   Employer _____
Telephone Number _____
                    "Notification to the Workers' Compensation Claimant"
Per Labor Commission Rule R612-2-22, an injured worker who files a claim for workers' compensation
benefits is required, if requested, to provide the name and address of medical providers who have provided any
medical treatment for up to the past 15 years (if claim is being Adjudicated). This is your notice that any and all
of the medical records within the custody of the medical provider that you have listed may be requested by the
party named on this form, as authorized by Rule R612-2-22.* The medical provider is required to release the
medical records per the rule, in order for the insurance carrier, self-insured employer, or the Labor Commission
to make a determination in your case. *You are required to sign the "Authorization to Release Medical
Records" Form 308A.

Please list all the medical providers for industrial injury first.

Please list any other medical providers who have treated you for <u>any</u> medical problems within the past _____
years (up to 15 years).

_____   _____
_____   _____
_____Zip_____   _____Zip_____
Telephone Number _____   Telephone Number _____

_____   _____
_____   _____
_____Zip_____   _____Zip_____
Telephone Number _____   Telephone Number _____

_____   _____
_____   _____
_____Zip_____   _____Zip_____
Telephone Number _____   Telephone Number _____

_____   _____
_____   _____
_____Zip_____   _____Zip_____
Telephone Number _____   Telephone Number _____
Please attach additional pages, if necessary.
Name of Party Requesting the Medical Records _____
Address _____
Telephone Number_____
Relationship to the Claim _____
***Medical Providers who have treated you related to your reproductive organs or for psychological problems do <u>not</u> have to be
listed unless you have made a claim for benefits related to these medical problems.
Failure to return this form to the requester may result in a delay or denial of your claim.**